SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

Rehabilitation Supports

NOTICE OF TERMINATION

Please Type or Print

(Must be completed within two days of termination)

Consumer's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Medicaid #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

The consumer is no longer eligible to receive Rehabilitation Supports for the reason below:

- ☐ Death
- ☐ Voluntary withdrawal
- ☐ No longer needs Rehabilitation Supports
- ☐ Has not received a service for two (2) consecutive calendar months (RS/I only)
- ☐ No longer Meets Eligibility Requirements (Specify): _____

EFFECTIVE DATE OF TERMINATION: _____ / _____ / _____
(must be completed)

As a result of this termination, the services and activities, which are currently provided and funded through Rehabilitation Supports, will no longer be funded in this manner.

☐ Individual Rehabilitation Supports ☐ Facility Based Rehabilitation Supports

Please Type or Print

Rehabilitation Supports Lead Clinical Staff Name: _____

Provider: _____

Address: _____

Phone: ( ) _____

Signature: _____ Date: _____
Lead Clinical Staff

Original: ☐ Recipient/Family Copy: ☐ Service Coordinator / Early Interventionist & Consumer's Record Copy: ☐ DDSN Finance Division